



## Flathead City-County Health Department

### Tobacco Use Prevention Program

Lisa Schlepp returned to the Tobacco Use Prevention Program this month. Lisa will work half time in Tobacco Use Prevention and half-time in the Cancer Control Program; Leslie will continue in Tobacco Use Prevention half-time as well.

In July, we received one new complaint of a violation of the Montana Clean Indoor Air Act against the Rail Line

Tavern in Marion; this was the third formal complaint filed against this establishment. An official reprimand was sent by the Health Officer and all pertinent information was forwarded to the County Attorney's Office. Further complaints may result in misdemeanor charges in accordance with the MCIAA. In August, one complaint of a violation was filed against Chinatown Res-

taurant in Kalispell. This was the establishment's first complaint; an educational letter was sent to the owner. Between October 1, 2009 and September 8, 2010, 99 valid complaints have been filed across the state; 7 in Flathead County.

MONTANA TOBACCO



### Montana Cancer Screening Program

In July/August we enrolled 190 women for breast and cervical cancer screenings. 26 women had abnormal breast results. 4 women had abnormal cervical results. 1 woman will be linked to Medicaid for breast cancer. 11 Native Americans were enrolled in the program and Tribal Health referred 11 women into the program.

In July/August we enrolled 34 patients for colon cancer screenings. 3 patients had positive FOBT cards and were referred for a colonoscopy.

The Montana Cancer Institute Foundation is working in partnership with Confederated Salish-Kootenai Tribal Health and the University of Montana to study how genetic factors might

influence Native Americans' response to cancer treatment. One of the first scientific goals of this project will be to focus on how a patient's genes might influence their response to tamoxifen, a medication very commonly used in treating breast cancer. UM researchers have already looked at the gene responsible for how tamoxifen produces its anti-cancer activity in 92 Salish-Kootenai tribal members, and have found that tamoxifen may not be effective in at least 10 percent of the people. While these results are preliminary and more work needs to be done, this could ultimately affect a large number of women taking tamoxifen for breast cancer treatment, to see which women may benefit the most from their therapy.

## Health Promotion Division

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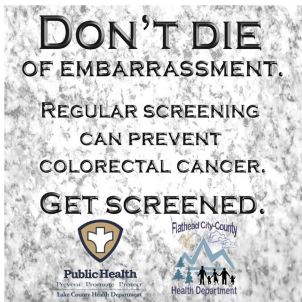


## Safe Kids Safe Communities

July and August brought new opportunities to get the word out about safety. Silverbrook Estates held an open house the end of July which featured a bike rodeo, helmet fitting, car seat safety and a buckle up message. The event was well attended. In August, Wendy participated in a parent/teen driving safety fair at Raceway Park. The event promoted the importance of teen safe driving and educated teens about making good decisions behind the wheel—whether as a passenger or driver. We had teens and their families sign pledge forms to commit to wearing their seat belts and driving safely. The Montana Highway Patrol had teens experience what is like to be impaired by

using the Fatal vision goggles, having them throw footballs at a target and perform the standard field sobriety tests. The goal is for them to experience how hard it is to do simple tasks while impaired and understand how difficult it is to drive a vehicle safely. Teens and their parents were allowed to drive on the race track as part of a distracted driving experience.

Wendy attended the annual Child Passenger Safety Technician Update and Instructor meeting in Helena. Staff from Safe Kids Worldwide updated the group on new car seats on the market, current installation techniques and more. The CPS instructors met on the 2nd day to discuss plans for 2011 classes and community needs.



### Comprehensive Cancer Control

Welcome to Lisa Schlepp as the new comprehensive cancer control specialist for Region 1. July starts the new fiscal year for the Cancer Control Program. Work plan requirements include outreach to all populations in the areas of breast, cervical and colorectal cancer. We have four clinics from Sanders County signed up to implement the Colorectal Cancer Toolbox Project to increase screening rate. Working together with the screening staff members, a newsletter was developed that will be distributed to providers to update them on cancer control issues and the screening program in general.

### Nutrition and Physical Activity

The required annual site visit with NAPA staff from MSU happened in August. This years work plan requires regional expansion of work-site wellness plans. Lake County Public Health as agreed to work on 6 strategies to increase consumption of fruits and vegetables and to increase their physical activity levels.



## Emergency Preparedness

READY FOR A DISASTER?



GET A KIT.



MAKE A PLAN.



BE INFORMED.

WWW.READY.GOV



The Public Health Emergency Preparedness grant cycle ended on August 31 and we are now rolling into a new fiscal year. The deliverables have been uploaded to the state Training and Communication Center and we will have a meeting in September to review the deliverables for this next fiscal year. Seasonal Flu clinic planning is already underway, with the Annual Flu clinic date set for October 13, 2010. In July, Jen participated in an emergency

response training up the North Fork. This radiological training included collaboration with Border Patrol, FBI, OES, and the 83<sup>rd</sup> Civil Support Team. It was an invaluable training and we made some excellent contacts for future trainings.

## Colorectal Cancer Screening Recommendations at a Glance

Risk Category	Age to Begin Screening	Recommendations
Average risk No risk factors	< Age 50	No screening needed
No symptoms	$\leq$ Age 50	Screen with any one of the following options: Tests that find Polyps and Cancer FS q 5 years CS q 10 years DCBE q 5 years* CTC q 5 years* Or Tests that primarily find cancer gFOBT q 1 year* FIT q 1 year *, ** sDNA ***
Increased Risk CRC or adenomatous polyp in a first-degree relative	Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first	Colonoscopy
Highest Risk Personal history for > 8 years of Crohn's disease or ulcerative colitis or a hereditary syndrome (HNPCC or FAP, AFAP)	Any age	Needs specialty evaluation and colonoscopy

\* If the test is positive, a colonoscopy should be done

\*\* The multiple stool take-home test should be used

\*\*\*Interval uncertain

## Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk or at High Risk

Risk Category	Age to Begin	Recommendation	Comment
<b>Increased Risk – Patients with History of Polyps at prior colonoscopy</b>			
Patients with small rectal hyperplastic polyps		Colonoscopy or other screening options at intervals recommended for average risk individuals	Exception – patients with hyperplastic polyposis syndrome. They are at increased risk for adenomas and colorectal cancer and need more intensive followup
Patients with 1 or 2 small tubular adenomas with low-grade dysplasia	5 to 10 years after the initial polypectomy	Colonoscopy	The precise timing within this interval should be based on other clinical factors (such as prior findings, family history and the preference of the patient and judgment of physician)
Patients with 3 to 10 adenomas or 1 adenoma > 1 cm or any adenoma with vilous features or high-grade dysplasia	3 years after the initial polypectomy	Colonoscopy	Adenomas must have been completely removed. If the follow up colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years.
Patients with > 10 adenomas on a single examination	>3 years after the initial polypectomy	Colonoscopy	Consider the possibility of an underlying familial syndrome.
Patients with sessile adenomas that are removed piecemeal	2 to 6 months to verify complete removal	Colonoscopy	Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment.
<b>Increased Risk Patients with Colorectal Cancer</b>			
Patients with colon and rectal cancer should undergo high-quality perioperative cleaning	3 to 6 months after cancer resection	Colonoscopy	In the case of nonobstructing tumors, this can be done by preoperative colonoscopy. In the case of obstructing colon cancer, CTC with intravenous contrast or DCBE can be used to detect neoplasms in the proximal colon.
Patients undergoing curative resection for colon or rectal cancer.	1 year after the resection (or 1 year following the performance of the colonoscopy that was performed to clear the colon of synchronous	Colonoscopy	This colonoscopy at 1 year is in addition to the perioperative colonoscopy for synchronous tumors. If the examination performed at 1 year is normal, then the interval should be 3 years. If that colonoscopy is normal the interval before the next subsequent exam should be 5 years.

	disease)		
<b>Increased Risk – Patients with a Family History</b>			
Either colorectal cancer or adenomatous polyps in a first degree relative before age 60 years or in 2 or more first degree relatives at any age	Age 40 years or 10 years before the youngest case in the immediate family	Colonoscopy	Every 5 years
Either colorectal cancer or adenomatous polyps in a first degree relative $\geq$ age 60 years or in 2 second degree relatives with colorectal cancer	Age 40 years	Screening options at intervals recommended for average-risk individuals	Screening should begin at an earlier age but individuals may choose to be screened with any recommended form of testing.

Source:

How to Increase Colorectal Cancer Screening Rates in Practice:

A Primary Care Clinician's Evidence-based Toolbox and Guide 2008